IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

August 28, 2007

Duke Van Campen, Administrator
The Haven
1119 West Hudson Avenue
Nampa, ID 83651

License #: RC-832

Dear Mr. Van Campen:

On June 12, 2007, a complaint investigation, state licensure survey was conducted at The Haven. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Maureen McCann, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

MAUREEN MCCANN, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

MM/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program

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June 26, 2007

CERTIFIED MAIL #: 7003 0500 0003 1967 0841

Patti Dennis, Administrator
The Haven
1119 West Hudson Avenue
Nampa, ID 83651

Dear Ms. Dennis:

Based on the complaint investigation, state licensure survey conducted by our staff at The Haven on **June 12, 2007,** we have determined that the facility failed to retain a licensed administrator responsible for the day-to-day operations for a period more than 30 days. Additionally, the facility failed to protect 3 of 4 (#2, 3, and 4) sampled residents from neglect.

These core issue deficiencies substantially limit the capacity of The Haven to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

Due to the due to the seriousness of these deficiencies, in accordance with IDAPA 16.03.22.910.02. the following enforcement actions are imposed:

1. **A consultant with an Idaho Residential Care Facility Administrator's license with a background in residential care will be obtained and paid for by the facility and approved by the Department. This consultant may not also be employed by the facility as a regular employee. The consultant is to be allowed unlimited access to the facility and its systems for the provision of care to residents. The name of the consultant with the person's qualifications and a copy of their license will be submitted to the Department for approval no later than July 6, *2007.***

2. **The Department approved consultant will submit a weekly written report to the Department commencing on July 13, 2007 and every Friday thereafter. The reports will address progress on correcting the deficiencies on the Statement of Deficiencies and the Non-core Punch List.**

3. **A provisional license is issued which is to be prominently displayed in the facility. Upon receipt of this provisional license, return the full license currently held by the facility.**

4. **When the consultant and the administrator agree the facility is in full compliance, they will notify the Department and a follow-up survey will be conducted.**

You have an opportunity to make corrections and thus avoid additional enforcement action. Correction of these deficiencies must be achieved by **July 27, 2007.** **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **July 9, 2007,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**July 9, 2007**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **July 9, 2007,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **July 12, 2007**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate additional enforcement action against the license held by The Haven.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/slc

Enclosure

c: Lynne Denne, Program Manager, Regional Medicaid Services, Region III - DHW

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R832	A. BUILDING _____ B. WING _____	C 06/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN, THE	1119 WEST HUDSON AVENUE NAMPA, ID 83651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiency was cited during the complaint and standard survey conducted at your residential care/assisted living facility. The surveyors conducting your survey were: Maureen McCann, RN Team Coordinator Health Facility Surveyor Debbie Sholley, LSW Health Facility Surveyor Survey Definitions: ADL's = Activities of Daily Living BM = bowel movement CNA = certified nursing assistant CVA = cardio vascular accident (stroke) po = by mouth (oral) POA = power of attorney pt's = patient's RN = registered nurse	R 000		
R 004	16.03.22.215.03 Licensed Administrator Requirement - 30 Days The facility may not operate for more than thirty (30) days without a licensed administrator. This Rule is not met as evidenced by: Based on interview, observation and record review it was determined the facility failed to retain a licensed administrator responsible for the day-to-day operations for a period more than 30 days. On 6/7/2007 at 2:36 p.m., the facility owner	R 004	RECEIVED JUL 10 2007 FACILITY STANDARDS	

Bureau of Facility Standards

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R 004	Continued From page 1 stated, her husband had been trying to get his administrator's license and he had taken the test three times, but had failed. A provisional administrator license (owner's husband) was observed hanging on a cork board in the staff office. This provisional license had expired on 11/30/2006. On 6/8/2007 at 4:00 p.m., the "current" administrator stated, that she had been the administrator for the facility since the end of April 2007. Surveyors confirmed the administrator's license was active. On 6/8/2007 at 4:10 p.m., the owner confirmed that the facillity had operated without a licenced administrator from 11/30/2006 until the end of April 2007. The facility had operated without a licensed administrator responsible for the day-to-day operations for more than 120 days.	R 004	The facility has a temporary administrator and will have permanent admin designated. (See attached plan of correction)	
R 009	16.03.22.525 Protect Residents from Neglect. The administrator must assure that policies and procedures are implemented to assure that all residents are free from neglect. This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to protect 3 of 4 (#2, #3 and #4) sampled residents from neglect. The findings include: On 6/7/2007 at 2:20 p.m., review of the May 2007 staffing schedule documented a caregiver worked alone from approximately 7:00 p.m. until approximately 10:00 a.m. the next morning.	R 009	See attached plan of correction - This was corrected upon exit from building -	

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R 009	Continued From page 2 There was no June 2007 schedule completed yet. The facility owner stated, "Since they left (house manager and a caregiver), they just walked out last week, I've been here all the time to fill in. I have an ad in the paper, but this is all the staff I have...there are 3 other caregivers and me. We are all working to fill in." The current facility census was 6 with 2 of the 6 residents bed-bound requiring 2 staff to reposition and attend to toileting needs. Review of Resident #3's record revealed the resident was admitted to the facility on 12/19/2005 with diagnoses which included a recent femoral fracture (5/22/2007) and dementia. The resident was bed-bound since the fracture and required total assistance from staff with ADL's including movement and positioning in bed. The physician ordered a Bledsoe brace to secure the fractured area (left femur at the knee) when the resident was being moved. On 6/8/2007 at 7:50 a.m., Resident #3 was observed in her bed. A strong urine odor was noted in the resident's room as well as in the hallway outside the room. On 6/8/2007 at 7:55 a.m., during an interview with 2 caregivers, one caregiver stated that "the resident can't be turned alone"...and has been mostly bed-bound since her fall on 5/22/2007. On 6/8/2007 between 8:15 a.m. and 8:40 a.m., 2 caregivers were observed changing the resident's clothing and bed linen. The caregivers were unsure how to stabilize the resident's left leg/knee when turning her. Neither was able to confidently apply the brace that was ordered by the physician to be used to stabilize the fracture during movement. One caregiver remarked while	R 009		

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R 009	Continued From page 3 holding the brace up in the air, "There is something to do with the tension, I don't know how to do it. Hospice is usually here and does this. They showed us, but I'm not sure how it goes." Further, it was observed the resident's night shirt had several urine stains at different stages of drying indicating the shirt had not been changed between urination. When questioned about the last time the resident had been changed, a caregiver replied, "I had help changing her last night before the other staff left and I went to bed." She further explained that she slept from approximately 9:00 p.m. until approximately 6:00 a.m. The caregiver confirmed she was the only staff person in the facility at night and she slept most of that shift. When asked if any residents required "night needs", the caregiver answered, "no." Both caregivers denied understanding the concept of "turning or repositioning" a bed-bound resident that cannot reposition herself. Additionally, they did not know what caused a pressure sore. The resident had a dime size area on her left heel that was black, as well as two 1.5 cm X 0.5 cm oblong reddened areas between her right scapula and armpit. The caregivers stated, "Those marks are from sweating." Furthermore, both caregivers stated they had not received training by facility nurse in caring for a bed-bound resident. "You mean the Hospice nurse?...I didn't know there was a facility nurse. I've never met her." Both caregivers confirmed they had never before taken care of a bed-bound resident. When asked if the facility administrator had provided them any training, both caregivers reported they did not know who the administrator was. The resident's record contained a physicians order dated 5/23/2007, which documented, "Bledsoe brace to left knee at 45 degree angle."	R 009		

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R 009	Continued From page 4 No documented evidence was found in Resident #3's record regarding the black spot on her heal or the reddened areas on her scapula. On 6/8/2007 at 8:50 a.m., when asked if Resident #3 had eaten breakfast, a caregiver held up a "sippy cup" full of liquid and stated, "Here is her breakfast. This (health shake) is what she has been having for meals since she has been stuck in bed because she pockets food (in her mouth)." The caregiver confirmed the resident had not routinely been offered meals besides health shakes since the resident became bed-bound. A physician's order dated 5/23/2007, documented, "offer ensure, nutritional supplement with each meal if po intake is less then 50%." The facility failed to protect Resident #3 from neglect by not providing the appropriate number of staff with the appropriate knowledge and skills to meet the resident's care needs when there was a significant change in condition. 2. Review of Resident #4's record revealed the resident was admitted to the facility on 9/3/06, with diagnoses which included dementia, type II diabetes, CVA, hypothyroidism and Vitamin B12 deficiency. The resident was no longer at the facility and therefore could not be observed nor interviewed. On 6/7/07 at 2:30 p.m., 2 caregivers stated, "(Resident #4) had diarrhea for 3 to 4 days. We kept changing her but we couldn't keep up." Both caregivers confirmed they did not call the facility's contract nurse or anyone else to let them know	R 009		

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R 009	Continued From page 5 the change in the resident's condition. Additionally, both caregivers confirmed they did not know who the facility administrator or contract nurse were. Review of Resident #4's "Resident Log" dated 5/28/07 through 6/3/07 documented the following: 5/30/07 - "(Resident #4) has been complaining of upset stomach today. She has diarrhea BM all day. Very pale and temperature of 102 degrees at 3:30 p.m." 5/30/07 - "(Resident #4) still not feeling good, she still has diarrhea, temperature 100 degrees at 7:30 p.m." Further review of the "Resident Log" documented the resident had medium to large amounts of diarrhea from 5/31/07 through 6/3/07. Additionally, it was documented the resident did not receive a shower for 3 out of the 4 days she remained at the facility. On 6/3/07 at 1:00 p.m. it was documented the resident was, "moved out of the facility at about 1:00 p.m. today." Further review of the resident's record revealed the resident was removed from the facility by her POA and taken to the hospital and admitted for dehydration and "chemical blood imbalance." The facility failed to protect Resident #4 from neglect by not seeking medical attention in a timely manner to prevent dehydration. 3. Review of Resident #2's record revealed the resident was admitted to the facility on 1/29/2007, with diagnoses which included Lewy Body Dementia with combative behaviors and was resistant to care.	R 009		

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R 009	Continued From page 6 On 6/8/2007 at 9:00 a.m., during an interview with a caregiver from an outside service agency the caregiver stated, "I usually get here around 8:30 every morning. I'm responsible for providing personal care." The caregiver further stated the resident needed to be repositioned every two hours and his adult briefs should be checked every four hours to ensure the resident's skin remains dry and clean. Additionally, the caregiver stated when he arrived at the facility each morning the resident's adult briefs were always urine soaked. On 6/8/2007 at 9:30 a.m., the two facility caregivers stated Resident #2 did not have any night time needs. However, both of the caregivers confirmed the resident required 2 person assist to reposition and change the resident's adult brief. When questioned about the last time the resident had been changed, a caregiver replied, "I had help changing him last night before the other staff left and I went to bed." She further explained that she slept from approximately 9 p.m. until approximately 6:00 a.m. The caregiver confirmed that she was the only caregiver in the facility at night and she slept most of that shift. When asked if any residents required "night needs", the caregiver answered, " no." Both caregivers denied understanding the concept of "turning or repositioning" a bed-bound resident that could not reposition himself. Furthermore, both caregivers denied having received training by the facility nurse in caring for a bed-bound resident. Neither caregiver knew who the facility administrator or facility nurse were. The facility failed to protect Resident #2 from neglect by not providing the appropriate number of staff with the appropriate knowledge and skills to meet the resident's care needs when there was	R 009		

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R 009	Continued From page 7 a significant change in condition. On 6/8/2007 at 9:00 a.m., during an interview with the facility owner, the owner explained the administrator came in when the house manager called her, "when she needed to sign something," but was not sure how often the administrator was at the facility. "The (house manager) was running the whole thing. When I come in I feel like a stranger. I only come about twice a week. I don't think I was looking deep enough; I was only looking at the residents...Since the house manager just walked out, I don't know where anything is." When asked who the facility RN was, the owner replied, "I hired a new nurse to start on June 18th." The owner did not know how often the facility nurse visited the facility or when she was in the facility last. When asked about staff working alone at night the owner stated, "The residents (#2 and #3) do not get up at night." When asked how their night needs including toileting is attended to, the owner replied, "Hospice comes in each morning and helps the staff with the residents (#2 and #3) and hospice also bathes them." The owner stated she did not know the night shift caregiver slept during the night. The owner confirmed the residents required 2 caregivers when turning or attending to the resident's toileting needs, but did not think the residents needed to be repositioned during the night while they were sleeping. On 6/8/2007 at 9:30 a.m., the survey team met with the owner and explained that at the current time, the facility could not adequately meet the needs for the 2 bed-bound residents (#2 and #3) due to several factors. Both Residents #2 and #3 required 2 caregivers to turn and reposition them as well as provide toileting needs and there were extended periods when only 1 caregiver was	R 009		

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R 009	Continued From page 8 working. Furthermore, the one caregiver who worked night shift slept from approximately 9 p.m. until approximately 6:00 a.m., during which time the residents were not repositioned or provided toileting needs. Also, the 2 caregivers as well as the owner did not have adequate training, knowledge or skills to care for bed-bound residents. The facility failed to provide basic services to Resident's #2, 3 and 4 to sustain their health and safety which resulted in neglect. The facility did not assure there was an adequate number of staff available nor that the staff had adequate training, knowledge or skills to care for bed-bound residents or a resident that had experienced a significant change of condition. The facility failed to assist Resident's #2 and #3 appropriately with turning, repositioning and toileting. The facility also failed to assist Resident #3 with eating solid food. Further, the facility failed to protect Resident #4 from neglect by not seeking medical attention in a timely manner to prevent dehydration. The facility was informed of the immediate danger situation regarding resident neglect on 6/8/2007 at 11:50 a.m. The facility provided an immediate plan of correction at that time.	R 009		

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June 26, 2007

Patti Dennis, Administrator
The Haven
1119 West Hudson Avenue
Nampa, ID 83651

Dear Ms. Dennis:

On June 12, 2007, a complaint investigation survey was conducted at The Haven. The survey was conducted by Maureen McCann, RN and Debra Sholley, LSW. This report outlines the findings of our investigation.

Complaint # ID00003078

Allegation #1: The facility did not assure all medications were kept in a locked area such as a locked box or room.

Findings: Based on observation and interview it was determined the facility did not assure the identified resident's medications were kept in a locked area.

On June 8, 2007 at 9:00 a.m., a medication cup containing 5 pills was observed in the top drawer of the resident's bedside table.

On June 8, 2007 at 9:15 a.m., a CNA for a outside service provider agency stated on two different occasions, he observed the resident's pills in the resident's room . He stated that on June 7, 2007 the resident's pills were left on top of the large dresser drawers. Additionally, he stated on June 6, 2007 he observed the resident's pills in the top drawer of the bedside table.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.01.a for failure to assure all medications were kept in a locked area or locked box. The facility was required to submit evidence of resolution within 30 days.

Based on the findings of the complaint investigation, the facility was found to be out of compliance with the rules for Residential Care or Assisted Living Facilities in Idaho. A Statement of Deficiencies has been issued to your facility. Please develop a Plan of Correction as outlined in the cover letter to the Statement of Deficiencies and/or Non-core issues were identified and included on the Punch List.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Jamie Simpson for

MAUREEN MCCANN, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

MM/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Maureen McCann

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June 26, 2007

Patti Dennis, Administrator
Haven, The
1119 West Hudson Avenue
Nampa, ID 83651

Dear Ms. Dennis:

On June 12, 2007, a complaint investigation survey was conducted at The Haven. The survey was conducted by Maureen McCann, RN and Debra Sholley, LSW. This report outlines the findings of our investigation.

Complaint # ID00003062

Allegation #1:	The facility is not assisting with medications and diets as ordered by the physician.
Findings:	Based on interview and record review it was determined the facility did not assist with medications as ordered by the physician.
Conclusion:	Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.525 for failure to provide the diet and medical care necessary to sustain the life and health of the residents. The facility was required to submit a plan of correction.
Allegation #2:	The facility did not provide adequate care regarding assistance with activities of daily living.
Findings:	Based on observation, interview and record review it was determined the facility did not provide adequate care to the identified residents with their activities of daily living.
Conclusion:	Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.525 for failure to provide adequate care and assistance to the residents with their activities of daily living. The facility was required to submit a plan of correction.

Allegation #3: The facility did not provide medical care in a timely manner.

Findings: Based on interview and record review it was determined the facility did not seek medical care in a timely manner for the identified residents.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.525 for failure to provide medical care in a timely manner. The facility was required to submit a plan of correction.

Allegation #4: The facility failed to protect the identified resident's privacy from his roommate's offensive actions.

Findings: Based on interview it could not be determined the identified resident's privacy was not protected.

On June 7, 2007 at 2:30 p.m., 2 current caregivers stated they had never witnessed the identified resident's roommate display offensive actions. They stated the roommate likes to sleep without clothes on. "Sometimes he gets up in the middle of the night and rummages threw his own dresser drawers. We explained about privacy and he has not done it since."

On June 12, 2007 at 7:00 p.m., the identified resident stated his roommate had never done anything that was offensive to him. He stated, "I stay in the room most of the time and he sets in the chair in the living room."

Conclusion: Unsubstantiated. Although the allegation may have occurred, it could not be validated during the complaint investigation.

Allegation #5: The facility owner screams and yells at the residents.

Findings: Based on observation and interview it could not be determined the facility owner yelled and screamed at the residents.

During tour of the facility on June 7, 2007 at 1:45 p.m., 4 of 6 current residents stated the facility owner had never yelled and screamed at them. Additionally, they stated all the caregivers treated them with dignity and respect and had not been verbally abusive.

Observation during the complaint investigation conducted from June 7, 2007 through June 12, 2007 revealed no evidence of the facility owner or caregivers screaming, yelling or being verbally abusive to the residents.

Conclusion: Unsubstantiated. Although the allegation may have occurred, it could not be validated during the complaint investigation.

Based on the findings of the complaint investigation, the facility was found to be out of compliance with the rules for Residential Care or Assisted Living Facilities in Idaho. A Statement of Deficiencies has been issued to your facility. Please develop a Plan of Correction as outlined in the cover letter to the Statement of Deficiencies and/or Non-core issues were identified and included on the Punch List.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Jamie Simpson for

MAUREEN MCCANN, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

MM/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Maureen McCann, RN, Health Facility Surveyor

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IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

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ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
The Haven	1119 West Hudson Ave	465-1829
~~Administrator~~	City	ZIP Code
Owner: Cynthia Williams	Nampa ID	83651
Survey Team Leader	Survey Type	Survey Date
Maureen McCann RN	Standard annual + Complaint	6/12/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	210	The facility did not conduct activities for the Resedents.	10 Jul 07 mc	
2	220.01a	The facilities current admission agreement did not reflect a 30 day notification for termination	10 Jul 07 mc	
3	300.01	The facility nurse did not assess the facility when there was a change in the residents condition (Res #3, 4)	10 Jul 07 mc	
4	305.01	The facility nurse did not conduct a nursing assessment of Resident #2 or 3's use of medicals	10 Jul 07 mc	
5	305.02	The facility nurse did not assure residents med orders were current and a copy of the actual written orders were present in the Residents records for Residents # 1 + 2. Resident #1 wife gives meds after Dicky MD.	10 Jul 07 mc	
6	305.03	The facility nurse did not conduct a nursing assessment on Residents # 3 + 4 when they experienced a change of condition.	10 Jul 07 mc	
7	305.08	The facility nurse did not assess, document and re-commend any health care related educational needs for the staff when Residents # 2, 3 become bed bound.	10 Jul 07 mc	

Response Required Date: 7/12/07

Signature of Facility Representative: Cynthia Williams

Date Signed: 6/12/07

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IDAHO DEPARTMENT OF HEALTH & WELFARE

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ASSISTED LIVING Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
The Haven	1119 West Hudson Ave	465-1829
~~Administrator~~	City	ZIP Code
Owner: Cynthia Williams	Nampa ID	83651
Survey Team Leader	Survey Type	Survey Date
Maureen McCann RN	STANDARD ANNUAL + COMPLAINT	6/12/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
8	310 01a	(Unidentified) pills were found in a medicine cup in Resident ~~#~~ #2's bedside table.	10Jul07 mm	
9	310 01d	Assistance with medications was not delegated appropriately by the facility nurse in compliance with the Board of Nursing rules.	10Jul07 mm	
10	310 01e	Observation of unlicensed assistive personnel (Board of Assistance) with medication to residents revealed that the caregiver punched pills into her own hand (dumped) before handing the pills to each resident.	10Jul07 mm	
11	310 03	Two boxes of Morphine Sulfate were observed setting on top of a file cabinet in the staff office. The office door was open & unlocked.	10Jul07 mm	
12	350 02	The Administrator did not complete a written investigation report for an incident occurring on 10/21/06 involving Residents #1 + 4.	10Jul07 mm	
13	350 07	The ~~former~~ administrator did not notify the bureau regarding a resident fall resulting in a fracture for resident #3.	10Jul07 mm	

Response Required Date	Signature of Facility Representative	Date Signed
7/12/07	Cynthia Williams	6/19/07

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
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Boise, ID 83720-0036
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ASSISTED LIVING
Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
The Haven	1119 West Hudson Ave.	465 1829
Administrator	**City**	**ZIP Code**
Owner: Cynthia Williams	Nampa ID 83651	83651
Survey Team Leader	**Survey Type**	**Survey Date**
Maureen McCann	Standard annual + complaint	6/12/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
14	600.01	The facility did not have staff up and awake for Resident #2 & 3 that have/might needed and are incapable of calling for assistance.	COS	
15	600.05	The administrator did not provide supervision for all personnel including the nurse. Caregivers and the nurse did not know who the administrator was when asked on 6/7/07.	10 Jun 07 MM	
16	600.06a	The administrator did not have 2 staff scheduled on night shift when Resident # 2 & 3 were 2 staff assist every 2 hours around the clock.	COS	
17	600.06b	The administrator did not have at least 1 staff scheduled at all times that was trained in 1st Aid and CPR.	COS	
18	620	The facility did not follow structured written training program to provide care for bed bound residents or assist c ADL's for Res #N.	10 Jun 07 MM	
19	~~625~~ 625	1 of 4 staff did not have 16 hours of job-related orientation training (8 hours - staff hired before current rule)	10 Jun 07 MM	
20	630.01	4 of 4 staff did not have specialty training in Dementia		
21	640	1 of 1 employees did not have 8 hours of continuing training in the last 12 months	10 Jun 07 MM	

Response Required Date	Signature of Facility Representative	Date Signed
7/12/07	Cynthia Williams	6/12/07

IDAHO DEPARTMENT OF HEALTH & WELFARE

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ASSISTED LIVING Non-Core Issues Punch List

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Facility Name	Physical Address	Phone Number
The Haven	1119 West Hudson Ave	465-1829
~~Administrator~~	City	ZIP Code
Owner: Cynthia Williams	Nampa ID	83651
Survey Team Leader	Survey Type	Survey Date
Maureen McCann	Standard Annual + Complaint	6/12/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
22	711.08e	Care notes did not include notification of the facility nurse when resident experienced a change of condition.	10AUG07 mm	
23	711.09	Residents 1, 2, 3 + 4 did not have a current list of medications, diet, treatments that were signed + dated by the physician.	10AUG07 mm	
24	725.01	The facility did not maintain currency of the admission + discharge register.	8AUG07 mm	
25	730.01g	1 of 4 staff did not have a current criminal history clearance -	10AUG07 mm	
26	730.02a	The facility did not have a current staff work schedule.	10AUG07 mm	
27	735.01	The refrigerator in the staff office had medications in it but did not have a temperature log to monitor the temperature.	COS	
28		* See items 28-31 on separate page *		

Response Required Date	Signature of Facility Representative	Date Signed
7/12/7	Cynthia Williams	6/12/07

IDAHO DEPARTMENT OF HEALTH & WELFARE

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ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
The Haven	1119 West Hudson Ave	465-1829
Administrator	**City**	**ZIP Code**
Owner: Cynthia Williams	Nampa ID 83651	83651
Survey Team Leader	**Survey Type**	**Survey Date**
Maureen McCann RN	SS + CI	6/12/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
	215.01	~~The facility did not assure the administrator~~		
28	215.01	The administrator did not assure that policies and procedures required in Title 39, Chapter 33, Idaho Code and IDAPA 16.03.22 were implemented.	10Jul07 mmc	
29	215.02	The administrator was not on site at the facility a sufficient amount of time to provide for safe and adequate care of the residents	10Jul07 mmc	
30	215.05	The administrator did not assure residents were not retained or admitted when the facility did not have the appropriate number of staff with the appropriate knowledge + skill to provide care to Resident #'s 2, 3, ~~5~~ 7 NMC and Res #4 (knowledge deficient)	10Jul07 mmc	
31	152.d	The Administrator did not notify residents that there was a sex offender living in the facility.	10Jul07 mmc	

Response Required Date	Signature of Facility Representative	Date Signed
7/12/07	Cynthia Williams	6/12/07